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JUDYANN BIGBY, M.D.
Secretary

October 12, 2007

Speaker Salvatore F. DiMasi, Massachusetts House of Representatives
President Therese Murray, Massachusetts Senate
Chairwoman Patricia A. Walrath, Joint Committee on Health Care Financing
Chairman Richard T. Moore, Joint Committee on Health Care Financing
Chairman Robert A. DeLeo, House Committee on Ways and Means
Chairman Steven C. Panagiotakos, Senate Committee on Ways and Means

Dear Senators and Representatives:

Pursuant to section 132 of Chapter 58 of the Acts of 2006, I am pleased to provide the General Court with the latest 60-day report of the Patrick Administration's progress in implementing Chapter 58. As with every update, the last two months have brought significant advancement in the implementation of chapter 58 as we continue to meet the deadlines for implementing various provisions of the law and continue to enroll people in health insurance at historic and heartening rates.

The last two months of health reform implementation were most notable for the transition, on October 1st, of the Uncompensated Care Pool to the Health Safety Net Trust Fund, including the transition to a claims based Medicare payment methodology, as discussed in Section 4. I am pleased to report that with the constructive input of advocates and providers, and the hard work of Commissioner Iselin, Medicaid Director Dehner and their staffs, the adoption of these regulations went as smoothly as it could have and the transition to the new system is well underway. We will be closely monitoring this new program.

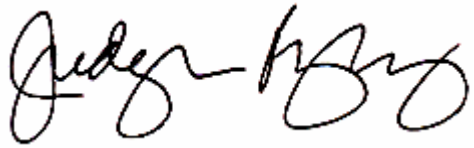
The last two months are also notable for the initiation of filing requirements for employers under the Fair Share Contribution and Health Insurance Responsibility Disclosure provisions on October 1st, as discussed in Section 7. At this date, it is too early to predict the rate of compliance with these requirements or to reliably anticipate the amount of revenue they will generate, but the collection of these reports marks an

important milestone in health reform implementation and the data generated from them is something that we will be watching carefully to fully understand the success of chapter 58.

Looking ahead to the next 60 day period, we in the Patrick Administration will be focusing on preparing for the December 31st deadline for individuals to be insured. Our current efforts to prepare for this deadline are discussed in Section 3. During the next two months, we will also be awarding Outreach and Enrollment grants to continue to publicize the good news of health reform and enroll as many people as possible in health insurance, as discussed in Section 1.

If you would like additional information on the activities summarized in this report, please do not hesitate to contact me or my staff.

Sincerely,



JudyAnn Bigby, M.D.

cc: Senator Richard R. Tisei
Representative Bradley H. Jones
Representative Ronald Mariano
Representative Robert S. Hargraves

Chapter 58 Implementation Report
Update No. 9

Governor Deval L. Patrick

Lieutenant Governor Timothy P. Murray

Secretary of Health and Human Services
JudyAnn Bigby, M.D.

October 12, 2007

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Section 1: MassHealth Update

The Office of Medicaid reports the following progress on Chapter 58 initiatives:

Insurance Partnership
MassHealth successfully implemented an increase in the income limit for eligibility in the Insurance Partnership from 200% to 300% of the federal poverty level (FPL), on October 1, 2006. This expansion allowed a greater number of low-income Massachusetts residents who work for small employers to participate in the IP program. As of September 2007, the Insurance Partnership has increased participation by 4,400 covered lives compared to September 2006.

In compliance with Chapter 58, MassHealth discontinued the Insurance Partnership (IP) employer subsidy for approximately 4,300 self-employed individuals on July 1, 2007. (Self employed individuals remain eligible for the employee subsidy.) As a result, expenditures for employer subsidies decreased by $253,050 in July 2007. On an annual basis this change will equal a decrease in the IP subsidy line item of approximately $3,000,000.

Children's Expansion up to 300% FPL
On July 1, 2006, MassHealth implemented expansion of MassHealth Family Assistance coverage to children in families with income greater than 200%, and up to 300% of the FPL. As of August 2007, there were 53,500 children enrolled in Family Assistance, up from 31,000 in June 2006. More than 16,800 of those children are new members and/or converted Children's Medical Security Plan members enrolled as a result of the income expansion.

MassHealth Essential
Effective July 1, 2006 the enrollment cap for MassHealth Essential was increased from 44,000 to 60,000. This allowed MassHealth to enroll more than 12,000 applicants who were on a waiting list at that time. As of August 2007, Essential enrollment was 52,700. Given the amount of additional enrollment capacity for the program, MassHealth does not anticipate having to reinstate the waiting list for Essential.

Wellness Program
Section 54 of Chapter 58 requires that MassHealth collaborate with the Massachusetts Department of Public Health (DPH) to implement a wellness program for MassHealth members. It specifies five clinical domains: diabetes and cancer screening for early detection, stroke education, smoking cessation, and teen pregnancy prevention. The law mandates co-payment and premium reduction for members who meet wellness goals. However, since members do not pay significant copayments or premiums, alternative incentives have been recommended.

The Wellness Program has completed research and data analysis to set a baseline for accurate tracking of MassHealth members' wellness behaviors. This work is essential for effective measurement and evaluation of the success of the Wellness project.

In February the Wellness Program project management team developed a two-phase implementation process in order to permit the development of a flexible and sustainable incentive program and to ensure that MassHealth members and providers support and buy-in to the idea of wellness. Phase one focuses on promoting and educating MassHealth members about the concept of wellness and healthy lifestyle activities. This education is coordinated with the MassHealth providers and with support from the Department of Public Health. Phase two of the Wellness Program, the incentive system, is in the planning phase to be implemented following research about the best way to track wellness activities and provide incentives to MassHealth members. Implementing the Wellness program incentive system requires surveying the marketplace which will be accomplished with a formal Request for Information (RFI) to vendors throughout the state.

MassHealth has met as scheduled with the Wellness Program External Advisory Group to discuss outreach and education ideas and incentive options for members. Additionally the Wellness Program management staff has met with MassHealth executives and CMS to discuss federal support for the member incentive system being investigated through the RFI. A draft of the RFI has been completed and is in the process of receiving final revisions from the Wellness program legal staffs prior to distributing it to MassHealth executives for sign-off and distribution to the public.

Since early April, the Wellness Program team has completed the design, review, finalization, and distribution of an English and Spanish wellness brochure, as well as an all-provider bulletin to educate providers about the program. In June the brochure was mailed to over 600,000 MassHealth member households. In September the brochure was added to the PCC plan materials catalog and the MassHealth customer service team has a supply to distribute to providers and members. The MassHealth Wellness Program Manager continues to present at regional MassHealth provider trainings about the Program, with a focus on opportunities to use the brochure to educate new and current MassHealth members. In October the annual MassHealth Pharmacy Program Information Sessions includes a presentation on the Wellness Program and the tobacco cessation benefit.

The project is on the following implementation time track:

- Creation of overall program structure: May through August 2006 (complete)
- Research and program design: September 2006 through February 2007 (complete)

- o Phase 1 & 2 implementation planning: January through May 2007 (complete)
- o Phase 1 outreach and education implementation: June 2007 (complete)
- o Phase 1 and 2 program activities and development and subsequent evaluation: July 2007 and ongoing (on schedule)

As previously reported, the copayment/premium reduction requirement in the law in Chapter 58, as originally passed, proved problematic. Most MassHealth members pay no premiums, and those who do generally pay negligible amounts. Consequently, MassHealth and DPH concluded that such an incentive structure would have little impact on member compliance, and therefore recommended changes to the legislation to allow for alternative wellness incentives. The legislature endorsed this approach in the FY 08 budget in line 4000-0700, "…that the executive office may reduce MassHealth premiums or copayments or offer other incentives to encourage enrollees to comply with wellness goals".

On September 28th the Wellness Program Year One Celebration event was held to acknowledge the great work in the planning and program design stage of the first year of the wellness program. The event included a review of the successes and lessons learned from the year as well as a group break-out discussion of future outreach and education planning ideas.

Outreach Grants

In the FY08 budget, $3.5 million was appropriated for the MassHealth, Commonwealth Care and Commonwealth Choice grant project to award grants to community and consumer-focused public and private non-profit organizations for activities directed at reaching and enrolling eligible Commonwealth residents in MassHealth and Connector Authority programs.

MassHealth decided to issue a new RFR and not automatically renew existing grants from FY07. The new RFR encompasses direct outreach grants, similar to grants in FY07 designated as "Model A" grants. The RFR solicited grant proposals from qualified community and consumer-focused public and private nonprofit organizations for activities directed at reaching and enrolling potentially eligible Massachusetts residents in MassHealth, Commonwealth Care and Commonwealth Choice. Proposals for this RFR were due on Wednesday, September 26, 2007 and 86 proposals were received. These proposals are expected to develop effective community-based strategies for reaching and enrolling eligible individuals into Commonwealth health insurance programs. All proposals are currently being reviewed and MassHealth expects to award 40-50 grants in mid October.

Although the FY08 RFR does not include the "Model B" outreach grants offered in FY07, MassHealth is currently developing a MassHealth, Commonwealth Care and Commonwealth Choice Outreach and Network Coordination Grant RFR to supplement the traditional outreach grant program and expects to issue this additional RFR during FY08. Grants are expected to be awarded to qualified organizations submitting proposals to serve as a lead organization to an

established network whose charge is to coordinate outreach and enrollment activities within a network of community based and consumer focused organizations.

Although, grant funding for FY07 awardees expired for a majority of the grantees in September 2007, organizations continue to be heavily involved in day-to-day outreach and enrollment activities on the local level. Many creative outreach strategies are being pursued and implemented to reach difficult to reach populations because of this funding.

MassHealth will also be creating, as required in line item 4000-0300 of the FY08 budget, a Health Care Reform Outreach and Education unit to coordinate statewide activities in marketing, outreach, and dissemination of educational materials related to Health Care Reform and to collaborate with the executive office of administration and finance, the department of revenue, the division of insurance, and the Commonwealth Health Insurance Connector Authority to develop common strategies and guidelines for providing informational support and assistance to consumers, employers, and businesses.

Section 2 Connector Authority Update

The Connector Authority continues to make significant progress in implementing many of the important initiatives contained in the landmark health care reform legislation.

Commonwealth Care
As of October 1, over 127,000 people have enrolled in Commonwealth Care, over 26,000 of which are in premium paying categories. Communication began in September around the November open enrollment period. All Plan Type 1 members (people whose income is below the federal poverty level) have been noticed regarding open enrollment. All other Plan Type members will be noticed starting in mid-October. During open enrollment Commonwealth Care members will be able to change their current plan for any reason. These changes, which will be effective 1/1/08, will be in place until 6/30/08. Open enrollment will run from 11/1/07 – 12/15/07.

Work is also underway with the Division of Health Care Finance and Policy (DHCFP) and MassHealth to appropriately communicate the transition from the Uncompensated Care Pool to the Health Safety Net. The Connector is working with DHCFP to notify all individuals who are Commonwealth Care-eligible but not enrolled about the availability of Commonwealth Care and that their uncompensated care pool coverage will be coming to an end.

The Premium Billing system continues to be upgraded. KPMG, the firm the Connector hired to review the premium billing system, is working with the Connector on a project with two phases: 1) evaluating the current premium billing system functionality, and 2) developing a roadmap that will allow for future program growth.

The Connector has launched an email-based tool that will allow for broad messaging and updates regarding Commonwealth Care. There are already close to 500 individuals on the dissemination list. Commonwealth Care fact sheets have been posted to the Connector's website in nine different languages. A Commonwealth Care web-based e-learning module has also been completed.

Commonwealth Choice
As of October 1, 8,306 individuals have enrolled in health insurance plans through Commonwealth Choice. The majority of Commonwealth Choice applications have been for Bronze or Young Adult Plans. The Connector continues to work on the Contributory Employer product for small employers. Commonwealth Choice fact sheets are now available on the web in five different languages.

Section 125
The Connector issued Administrative Bulletin 03-07 that provides guidance on several issues related to the section 125 plan requirements including a change to the section 125 plan document filing requirement. The Connector has also completed Section 125 and Voluntary Employer guides, which are now published and posted on the Connector's website.

3,000 employers have decided to allow their employees not eligible for their main line benefit to shop pre-tax through the Connector, including Raytheon, Fidelity, Harvard University, Staples, Children's Hospital, the City of Boston and the Commonwealth of Massachusetts. These 3,000 employers have 50,399 eligible employees.

Website
The Connector Authority website, www.mahealthconnector.org, continues to have over 14,000 web visits per week. Employers who shop through the Connector are now able to print Commonwealth Choice materials for their employees, manage their account, and track employee enrollments. The Connector has also launched automated premium billing and payment transmission to and from employers

Operations
The Certificate of Exemption that individuals will be able to request from the Connector in order to try to avoid paying a penalty under the individual mandate has been completed. The certificate, along with instructions, will be posted on www.mahealthconnector.org.

Marketing and Outreach
September 15 was Connector Day at Fenway Park. The purpose of this day was to celebrate health care reform and continue to highlight the benefit of health insurance. A two-page spread on health care reform appears in the September issue of the Red Sox program and the Health Connector continues to staff an information booth on the Main Concourse at every home game.

The Connector continues targeted marketing and outreach through radio, TV, and print ads. The outreach this Fall will focus on enrolling uninsured individuals before they may be penalized by the mandate. A grassroots outreach effort is also underway to assist these endeavors on a more community-based level.

Section 3: Individual Mandate Preparations

The Department of Revenue reports the following progress on Chapter 58 initiatives:

MA 1099-HC (for health care)

Most taxpayers with private health insurance, either purchased on their own or obtained through an employer, will receive a MA 1099-HC form from their insurance carrier or their employer if the employer is self-insured. This form will contain the information that taxpayers will need to complete their 2007 tax return. DOR will verify an individual's coverage, by matching the information reported on the tax return with the information provided by insurance carriers or employers on the MA 1099-HC. DOR continues to work closely with insurance carriers and employers who are responsible for sending these forms. For more information about this process, including a copy of the MA 1099-HC form and the electronic reporting requirements, please visit DOR's website at: www.mass.gov/dor/hcinfo.

2007 Tax Forms

In July, DOR published the first draft of Schedule HC, Health Care Information, which taxpayers will file with their 2007 income tax return to show either proof of health insurance coverage or that no affordable health insurance was available to them. The draft Schedule HC along with draft instructions and a worksheet is available for review on DOR's website: www.mass.gov/dor/hcinfo. DOR continues to seek feedback from consumer groups, advocates and tax practitioners to ensure that the form is as easily understood as possible. Over the next few months, DOR will finalize the form for the start of the tax season.

Appeals Process

DOR and the Connector continue to make progress on the process by which taxpayers may file an appeal claiming that a hardship prevented their purchase of affordable health insurance coverage in tax year 2007. The Connector will review and issue determinations on these appeals. The appeals process involves three steps. First, the taxpayer must complete Schedule HC-A, Health Care Appeals, and include it with his or her income tax return. Second, the taxpayer will receive a follow-up letter and form, which must be completed, stating the grounds, and providing documentation to substantiate the claim for hardship, within a specified timeframe. Failure to submit the form and provide documentation in the required time frame will result in a dismissal, and the taxpayer will be issued a bill based on the loss of the personal exemption. Third, the Connector will review the claim and documentation. The taxpayer may be required to attend a hearing to review his or her case. The Connector will notify the taxpayer directly as to the outcome of the requested appeal. A denial by the Connector may be appealed only to the Superior Court. If the Connector denies the taxpayer's appeal, he or she will be issued a bill based on the loss of the personal exemption for tax year 2007.

Outreach

DOR mailed close to 3 million postcards to taxpayers and over 193,000 letters to employers, informing them of the insurance mandate in the new law. General Health Care information is currently available on DOR's site at www.mass.gov/dor/hcinfo. This site is continuously updated with new information and guidance. Over the next few months, DOR will work on the following outreach efforts:

- Creating a video tutorial on the DOR website which will walk taxpayers step-by-step through completing the Schedule HC. This video will also be made available to various advocacy and tax professional organizations via CD.

- Distributing posters to various state agencies to help inform taxpayers about the 2007 tax year requirements with regard to Schedule HC.

- Generating a one-page handout containing key information for taxpayers and employers regarding HC information which will be available to DOR Auditors and Collectors on the road and in DOR District Offices.

- Training DOR customer service personnel to answer general taxpayer inquiries about the Schedule HC and the income tax forms.

Section 4: Health Safety Net Trust Fund and Essential Community Provider Trust Fund Grants

Health Safety Net Trust Fund Regulations

The Division of Health Care Finance and Policy was required to propose regulations implementing the Health Safety Net Trust Fund for October 1, 2007. Chapter 58 requires that the regulations address eligibility criteria for reimbursable services, the scope of health services eligible for reimbursement from the fund, the standards for medical hardship, the standards for reasonable efforts to collect payments for the cost of emergency care and the conditions and methods by which hospitals and Community Health Centers will be paid by the fund. In advance of this regulatory proposal, the Division conducted a consultative session on June 19, 2007. The purpose of the session was to solicit input from interested parties and stakeholders in order to inform the process of formulating policy options regarding services and eligibility under the new Health Safety Net Regulations.

After considering the input received the Division issued proposed regulation 114.6 CMR 13.00 Health Safety Net Eligible Services. A public hearing was held on this proposal on August 22, 2007. The public hearing was very well attended and many interested parties offered oral and written testimony on various components of the proposed regulations. After careful consideration of the testimony, the Division modified some of the elements of the proposal and adopted the regulation on September 21, 2007. The regulation became effective October 1, 2007, and can be found on the Division's web site, www.mass.gov.dhcfp under regulations, 114.6 CMR 13.00.

The Division also conducted a public hearing on the proposed regulation 114.6 CMR 14:00 Health Safety Net Payments and Funding. This regulation sets out the conditions and methods by which acute hospitals and Community Health Centers can file claims for services and receive payments from the Health Safety Net Trust Fund. The regulation implements the requirements of Chapter 58 to pay hospitals based upon claims using a Medicare based payment method. The proposed regulation also implements the requirement that the Health safety Net trust Fund pay Community Health Centers using the Federally Qualified Health Center visit rate. After considering the public hearing testimony, the Division adjusted some elements of it proposal and adopted the regulation on September 21, 2007. The regulation went into effect October 1, 2007 and can be found on the Division's web site, www.mass.gov.dhcfp under regulations, 114.6 CMR 14.00.

Essential Community Provider Trust Fund

Another responsibility of the Health Safety Net Office under Chapter 58 and as amended by Chapter 118G Section 35 (b)(6) is to administer the Essential

Community Provider Trust Fund. The purpose of this fund is to improve and enhance the ability of hospitals and community health centers to serve populations in need more efficiently and effectively including but not limited to the ability to provide community-based care, clinical support, care coordination services, disease management services, primary care services and pharmacy management services. The criteria for selection includes the institution's financial performance; the services they provide for mental health or substance abuse disorders, the chronically ill, elderly, or disabled; and the pace, payer mix, prior years awards, cultural and linguistic challenges, information technology, twenty-four hour emergency services and extreme financial distress.

The Division of Health Care Finance and Policy, working with the Executive Office of Health and Human Services, developed a grant application process and scoring/review system, similar to the process employed last year. This process considered applicants financial and essential characteristics in order to determine grant allocation amounts from the $28 million dollar fund. A cover letter, grant application and instructions were sent to providers and posted on EOHHS/DHCFP websites on July 13, 2007. Hospital and Community Health Center applications were due on July 31, 2007. Over 80 hospitals and community health centers have applied and have requested over $108 million in funding. DHCFP and EOHHS staff have reviewed and scored these applications based upon the criteria specified.

The supplemental budget appropriation recently passed by the legislature and approved by the Governor included additional funding of $9.5 million for the Essential Community Provider Trust Fund. This action brought the total available funding to $37.5 million.

On Thursday October 11, the EOHHS announced that 69 providers would receive grants from the Essential Community Provider Trust Fund. The distribution of grants awards include:

• Twenty-five acute care hospitals received a total of $26.7 million from the ECPTF representing approximately 72% of the funding available. The average grant award was $1.1 million

• One non-acute care hospital received a $2 million grant from the ECPTF. This represents approximately 5% of the total funding available.

• Forty-three community health centers received a total of $8.8 million from the ECPTF. The average grant award is $205,000 representing approximately 24% of the funding available.

It is anticipated that these grants will be distributed to providers beginning in November after the contracts for the awards are completed.

Section 5: Public Health Implementation

Community Health Workers (CHWs)

Section 110 of Chapter 58 requires the Massachusetts Department of Public Health (MDPH) to make an "investigation relative to a) using and funding of community health workers by public and private entities, b) increasing access to health care, particularly Medicaid-funded health and public health services, and c) eliminating health disparities among vulnerable populations."

MDPH has completed a literature review on the role of CHWs in increasing access to health care and in reducing health disparities. In addition, the MDPH Community Health Worker Advisory Council held its first meeting on August 15, 2007, chaired by Commissioner Auerbach and attended by over 40 representatives of CHW organizations, government, academic institutions, and health care providers. The Council was divided into four subcommittees addressing finance, research, survey, and workforce training. These workgroups are regularly meeting to develop recommendations for creating a sustainable CHW workforce and program. A report summarizing their findings and recommendations will be considered by the Advisory Council and MDPH, as well as distributed to the legislature. The next full Advisory Council meeting is scheduled for November 14, 2007.

Health Care Reform Information Sessions

In collaboration with the Connector Authority, MDPH has organized four information sessions for senior staff members. These trainings provide insight into: the health care reform legislation; the role of Connector; Commonwealth Care and Commonwealth Choice; and avenues to obtain additional information. To date, approximately 300 MDPH staff members have attended one of these sessions. MDPH staff members are expected to understand the legislation, monitor programs to ensure compatibility with health care reform, and assist clients in seeking coverage. In addition, in collaboration with Health Care For All, MDPH is hosting trainings for contracted agencies by region and/or health topic, as well as for specific Bureaus. Three sessions have already been scheduled, with several more being planned.

Outreach and Educational Materials

MDPH is in the process of distributing Commonwealth Connector fliers and materials to Department locations visited by members of the general public. In addition, MDPH staff members who attended one of the information sessions have received health care reform related materials to bring back to their respective programs. Lastly, MDPH is developing a page on its website to provide information about health care reform and a link to the Commonwealth Connector website.

Assessment of Public Health Programs
MDPH is currently assessing certain internal programs to ensure that the services offered by the Department are appropriate, cost-effective, and compatible with health care reform.

Section 6: Insurance Market Update

Health Access Bureau

The Division of Insurance developed job descriptions and posted positions for an actuary, a research analyst and a financial analyst within the newly formed Health Access Bureau, pursuant to chapter 58. The Division is currently interviewing for these positions. To complete some of the duties required by the Health Access Bureau prior to filling the internal positions, the Division has contracted with outside actuaries to develop targeted reports.

Minimum Standards and Guidelines

Chapter 58 of the Acts of 2006 directs the Division of Insurance, in consultation with the Connector, to establish and publish minimum standards and guidelines at least annually for each type of health benefit plan provided by insurers and health maintenance organizations doing business in the Commonwealth. The DOI has initiated discussions with the Connector, the carriers and other interested parties on such standards and guidelines.

Section 7: Employer Provisions

Division of Health Care Finance and Policy

Division of Health Care Finance and Policy (DHCFP) reports the following progress on implementation of the requirements imposed on employers by Chapter 58.

Employer Fair Share Contribution

The Division of Health Care Finance and Policy adopted 114.5 CMR 16.00: Employer Fair Share Contribution on September 8, 2006. This regulation governs the determination of whether an employer makes a fair and reasonable premium contribution to the health costs of its employees, as required by Chapter 58. The Division has determined that Section 16.03 (2) (a), "Employee Leasing Companies," requires clarification. Under that section, employee leasing companies will be required to perform the fair share contribution tests separately for each client company. Although the employee leasing company is responsible for collecting and remitting the Fair Share Contribution on behalf of its client companies, the client company is responsible for any Fair Share Contribution liability.

The Division of Unemployment Assistance held a public hearing on its proposed regulations governing the administration and collection of the Employer Fair Share Contribution. The regulations were subsequently adopted.

Employer Surcharge for State-Funded Health Costs

The Division of Health Care Finance and Policy initially adopted Regulation 114.5 CMR 17.00: Employer Surcharge for State Funded Health Costs on December 22, 2006, with an effective date of January 1, 2007. This regulation implemented the provisions of M.G.L. c. 118G, § 18B. Following enactment of Chapter 450 of the Acts of 2006 on January 3, 2007, the Division repealed this regulation. Chapter 450 changed the effective date of M.G.L. c. 118G, § 18B from January 1, 2007 to July 1, 2007.

The Division adopted regulation 114.5 CMR 17.00 on an emergency basis on July 1, 2007. The regulation reflects the amended legislation, clarifying that a "non-providing employer" subject to surcharge is an employer that does not comply with the requirement in M.G.L. c. 151F to offer a Section 125 cafeteria plan in accordance with the rules of the Connector. The effective date of the regulation is consistent with the July 1, 2007 effective date of the Section 125 cafeteria plan requirement implemented by the Connector. The Division conducted a public hearing on the emergency regulation on September 6, 2007 and has subsequently certified the regulation.

Health Insurance Responsibility Disclosure

The Division of Health Care Finance and Policy initially adopted 114.5 CMR 18.00: Health Insurance Responsibility Disclosure as an emergency regulation effective January 1, 2007, but subsequently repealed the regulation. The regulation implemented M.G.L. c. 118G, § 6C, which was previously effective on January 1, 2007. Chapter 450 of the Acts of 2007, which became effective on January 3, 2007, changed the effective date of M.G.L. c. 118G, § 6C from January 1, 2007 to July 1, 2007.

The Division adopted regulation 114.5 CMR 18.00 Health Insurance Responsibility Disclosure on an emergency basis on July 1, 2007. The regulation incorporates the provisions of Chapter 324 which significantly reduce the amount of information the Division is required to collect from employers. In addition, only employees that have declined to enroll in employer sponsored insurance or to participate in a Section 125 cafeteria plan are required to sign an Employee HIRD form. Employers will retain Employee HIRD forms and will submit them upon request by either the Division of Health Care Finance and Policy or the Department of Revenue. The Division has posted a copy of the Employee HIRD on its website at:
http://www.mass.gov/Eeohhs2/docs/dhcfp/g/regs/employee_hird_form.pdf

The Division conducted a public hearing on the emergency regulation on September 5, 2007 and subsequently certified the regulation.

Division of Unemployment Assistance

The Division of Unemployment Assistance at the Executive Office of Workforce and Labor Development reports the following progress on the implementation of the provisions of chapter 58 affecting employers.

The first annual employer filing period for the Fair Share Contribution (FSC) Report and the Employer Health Insurance Responsibility Disclosure (HIRD) Report began on schedule on October 1, 2007 at DUA. The filing period commenced after the September 30 close of the 12-month base period for determining employer liability for the fair share assessment and for submitting the HIRD report to the Division of Health Care Finance and Policy (DHCFP). Employers required to file with DUA were notified by mail during the week of September 24, and were provided with detailed instructions and contact information at DUA. This on-line reporting system offers “one stop” filing of both the FSC and HIRD reports to DUA and DHCFP respectively. Reports are due from employers on November 15, 2007; however, the filing system will be available to accept employer reports all year.

DUA will provide the FSC & HIRD report data to DHCFP and the Connector, pending legislative approval of technical amendments authorizing DUA to do so, thus providing these health care agencies with information necessary to carry out their missions.

Staff members of the newly formed Fair Share Contribution Unit at DUA are providing program information and filing instructions to employers who call in or email the agency for assistance in completing their reports. DUA has worked cooperatively with DHCFP to ensure that employers who need specialized assistance in completing the HIRD portion of the on-line report can be directly connected through a linked phone system to DHCFP customer service staff.

Section 8: Health Care Quality and Cost Council

The Health Care Quality and Cost Council has continued meeting regularly to make progress on the statutory goal of reducing cost while improving quality of care for the Commonwealth. The Council and its committees have heard from many experts and worked to shape an agenda for advancing cost and quality goals for Massachusetts.

Statewide Goals for the Commonwealth

The Council held its Annual Meeting on September 21, 2007 at the John F. Kennedy Presidential Library and Museum. Over 170 policy-makers, health care providers, health care consumers, representatives of health plans and professional associations, and others came together for this event to highlight the statewide goals established by the Council. Dean Stuart Altman of the Brandeis University Heller School gave a keynote address on the rise in health care costs. Panel discussions included Preventing Hospital Acquired Infections, Reducing Racial and Ethnic Disparities, and Public Reporting of Health Care Quality and Cost Data.

The Council established four new Committees to focus on statewide health care quality improvement goals established by the Council that are intended to lower or contain the growth in health care costs while improving the quality of care, including reductions in racial and ethnic health disparities. The Council established these goals as required by M.G.L. c.6A, s.16L.

The four Committees are: Communications and Transparency, Chronic Disease Prevention and Management, End of Life Care, and Patient Safety. Each Committee will focus on one of the statewide goals established by the Council, as well as reduction in disparities and cost containment in their focus area. The Committees are charged with conducting the analysis mandated by the Council's statute. For each goal, the committees will:

- "identify the steps needed to achieve the goal;
- estimate the cost of implementation;
- project the anticipated short-term or long-term financial savings achievable to the health care industry and the commonwealth, and
- estimate the expected improvements in the health status of health care consumers in the commonwealth." [MGL c.6A s.16L(a)] and
- "… develop performance measurement benchmarks for its goals and publish such benchmarks annually, after consultation with lead agencies and organizations and the council's advisory committee." MGL c.6A, s16L(g)

Website Development

The Council has taken several steps toward creating a website that will provide comparative cost and quality information about health care services in a user friendly format, as required by M.G.L. c.6A, s.16L.

- The Council promulgated a regulation that set standards for collecting claims data from insurers. The Council will use this data in order to post comparative cost and quality information by service and by provider on its website. The Council will also use this data to improve its understanding of both the drivers of health care costs and the variation in practice patterns and quality of care.

- The Council contracted with a Communications and Web Design Consultant, Solomon McCown, Inc., to develop methods to communicate health care quality and cost information in an easily understood format. Solomon McCown has begun conducting market research to inform this process.

- The Council contracted with a Health Claims Data Manager, the Maine Health Information Center (MHIC), to collect claims data from insurers and edit, maintain and secure that data. Licensed Massachusetts carriers will begin submitting claims data to MHIC on December 1, 2007.

- The Council plans to contract with two more entities, one to analyze the claims data to produce cost and quality measures, and the other to build the website application.

Section 9: Recommended Changes to Chapter 58

The General Court has passed two separate bills making amendments to Chapter 58 to ensure the successful implementation of all aspects of Health Care Reform.

There still remain, however, a number of outstanding issues that should be addressed to allow the Connector, the Division of Unemployment Assistance, the Department of Revenue, the Division of Health Care Finance and Policy and the Office of Medicaid to implement health reform as the legislature intended. As of the date of publication, the Health Care Finance Committee has released a bill, H 1117, to make many technical changes to chapter 58, but neither the full house, nor the Senate had acted on the bill. Many, but not all of the changes proposed below are included as part of H. 1117.

Executive Office of Health and Human Services/MassHealth

1) Including S-CHIP and 1115 demonstration programs in the definition of "Creditable Coverage": The definition of "creditable coverage," used in implementing the individual mandate, should include not only Title XIX coverage as currently provided, but also coverage under the 1115 demonstration waiver and under Title XXI of the Social Security Act, the State Children's Health Insurance Program (SCHIP). Both SCHIP and the waiver provide for comprehensive coverage that should be recognized as creditable coverage under Health Care Reform. In addition, coverage providing for emergency services only (section 1903(v)) should be excluded from this definition (because it is not comprehensive).

Proposed Amendment Language:

Section 1 of chapter 111M of the General Laws, as most recently amended by chapter 324 of the acts of 2006, is hereby further amended by striking the words "Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928" in the definition of "Creditable coverage" and inserting in place thereof the following words:- Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1903(v) and section 1928, Title XXI of the Social Security Act, and the MassHealth demonstration waiver approved under Section 1115(a) of the Social Security Act or identical state funded coverage.

2) Income Ceiling for the Self-Employed in the Insurance Partnership program: Chapter 58 of the Acts of 2006 amended the definition of "eligible employee" in the insurance partnership statute to change the income ceiling from 200% FPL to 300% FPL; however, a corresponding

change was not made in the definitions of “Eligible self-employed single individual” and “Eligible self-employed husband and wife.” The income ceilings for the self-employed and the employed should be the same. Federal approval has been obtained for treating them the same with an income ceiling of 300% FPL.

Proposed Amendment Language:
Subsection (1) of section 9C of chapter 118E of the General Laws, as most recently amended by chapter 324 of the acts of 2006, is hereby further amended by striking the words “200 per cent of the federal poverty level” in the definitions of “Eligible self-employed single individual” and “Eligible self-employed husband and wife” and inserting in place thereof the following words:- 300 per cent of the federal poverty level

3) Deadline for MassHealth Primary Caregiver Study: Chapter 58 requires the Secretary of Health and Human Services to study the costs of allowing primary care givers to qualify for MassHealth if they care for an elderly or disabled family member full time. The study was due July 1, 2007. EOHHS needs until January 31, 2008 to complete the study.

Proposed Amendment Language: Section 129 of Chapter 58 of the Acts of 2006 shall be amended in the last sentence by striking the words, “July 1, 2007,” and inserting in place thereof the following: - January 31, 2008.

The Division of Health Care Finance and Policy

1) Extending Time for Computing Free Rider Surcharge: Chapter 58 of the Acts of 2006, as amended by Chapter 450 of the Acts of 2006, established a "Free Rider Surcharge" under M.G.L. c. 118G, §18B on employers that do not offer employees the opportunity to purchase health insurance through a Section 125 Cafeteria Plan in accordance with the rules of the Connector. The surcharge is based on the amount of Uncompensated Care Pool services provided to the employer's employees and employee dependents during the hospital fiscal year. M.G.L. c. 118G, §18B requires the Division to notify employers of their liability under this provision "assessed by the Division not later than 3 months after the end of each hospital fiscal year." The Division needs 180 days, rather than 90 days, to compute the employer surcharge liability as hospitals have 45 days after the close of the fiscal year to submit claims, and the Division must perform a data match with the Department of Revenue to verify the accuracy of the employer liability.

Proposed Amendment Language: SECTION XXX. Section 18 B of chapter 118G, as added by section 44 of Chapter 58 of the Acts of 2006, is hereby amended in subsection (b) by striking the number "90" and inserting in place thereof the number "180".

The Connector Authority

1) Allowing Eighteen Year Olds to Buy in to Young Adult Plans: Chapter 58 allowed for the creation of more affordable insurance products for young adults, ages 19 to 26. This language should be amended to allow 18 year olds to purchase young adult plans, because the individual mandate will apply to 18 year olds who may not be eligible for MassHealth or Commonwealth Care.

Proposed Amendment Language: Section 10 of c. 176J, as amended by c. 58 of 2006, is hereby amended by deleting from the second sentence the number "19" and replacing it with the number "18."

2) Collection of Section 125 Plans by Connector: Language in chapter 151F, as amended by Chapter 58, should be further amended to remove the requirement that the Connector collect section 125 plans from all employers. The Connector should maintain the authority to request any employer's section 125 plan, to help enforce compliance, but need not collect one from every employer.

Proposed Amendment Language: Section 2 of chapter 151F of the General Laws, as amended by c. 58 of 2006, is hereby amended by deleting the second sentence and replacing it with the following sentence: - A copy of such cafeteria plan shall be made available to the Connector upon request.

Division of Unemployment Assistance

1) Authorization to Share Information with the Connector: The Division of Unemployment Assistance (DUA) needs legislative authorization to share information it will receive from businesses concerning the health insurance they offer with the Division of Health Care Finance and Policy and the Connector Authority. The Legislature, in section 17 of the FY08 budget, intended to authorize DUA to share information with the Division of Health Care Finance and Policy (DHCFP), but did not also authorize DUA to share information with the Connector. The Governor sent section 17 back with amendments (filed as House Bills 4156 and 4157) to ensure that DUA can share information with both DHCFP and the Connector. The Legislature has yet to act on those amendments.

Proposed Amendment Language: SECTION 2. Subsection (c) of section 46 of chapter 151A of the General Laws, as appearing in the 2004 Official Edition, is hereby amended by adding the following clause:- (7) to the Division of Health Care Finance and Policy under an interagency agreement for the purposes of the administration and enforcement of

sections 6B, 6C and 18B of chapter 118G and section 188 of chapter 149; to the Commonwealth Health Insurance Connector for the purposes of the administration and enforcement of chapter 151F and for the administration of the fair share employer requirement under section 188 of chapter 149; to the Commonwealth Health Insurance Connector for the purposes of the administration and enforcement of chapter 151F and for the administration of the fair share employer requirement under section 188 of chapter 149.

Division of Insurance

1) Eliminate Duplicate Section Numbers: Chapter 58 added section 4R to the M.G.L.c.176G, the requirement for dependent age up to age 26. However, Chapter 172 of the Acts of 2006, An Act Relative to HIV and Hepatitis C Prevention, also inserted a new section 4R of M.G.L.c.176G. Similarly, Chapter 58 added section 8Z to M.G.L. c. 176A and 4Z to M.G.L.c. 176B. However, Chapter 172 of the Acts of 2006, An Act Relative to HIV and Hepatitis C Prevention, also inserted section 8Z to M.G.L. c. 176A and 4Z to M.G.L.c. 176B. We recommend that in both cases, one the section numbers be changed to avoid confusion.

Department of Revenue

1) **Authorization for Release of Health Insurance Information from EOHHS to DOR**: The Department of Revenue (DOR) is responsible for enforcing the individual mandate through the state income tax returns. The most challenging issue for DOR is how to confirm that the health insurance information reported by the taxpayer is accurate. The current plan is for certain employers and insurance carriers to mail a 1099-HC document to everyone who has health insurance. Taxpayers will use this document to transcribe health insurance information onto the tax return. Every carrier or employer who issues 1099-HC's will also send to DOR an electronic tape that contains all of the data included on the 1099-HC. DOR will match the data on the tax return to that data, and if the data does not confirm the claimed coverage (i.e., the taxpayer entered the number incorrectly or the taxpayer didn't receive a 1099-HC) then DOR would like the ability to verify coverage using information maintained by the Executive Office of Health and Human Services (EOHHS). EOHHS collects health insurance information directly from insurance carriers to identify private health insurance for Medicaid patients and individuals who use the uncompensated care pool. This information can only be used for certain authorized purposes. This amendment would authorize EOHHS to release information received from holders of health insurance to the DOR for purposes of enforcing the individual mandate.

Proposed Amendment Language: The eighth paragraph of section 23 of chapter 118E as recently amended by section 4 of chapter 42 of the

Acts of 2007 is hereby further amended by adding the following sentence after the words “policy of insurance.”: - Upon request from the Department of Revenue, the Division shall make information received from holders of health insurance information available to the Department of Revenue to enable the Department to determine whether a person is covered under insurance as required under chapter 111M.

2) **Authorization for DOR to Share Information with Other Agencies for HCR Enforcement Purposes:** The following two amendments allow the Connector, the Division of Health Care Finance and Policy (DHCFP) and the Executive Office of Health and Human Services (EOHHS) to receive wage and tax information for health care reform from DOR. Information on a tax return is considered confidential and may not be disclosed to any other entity unless authorized by law. DOR needs to share information from the tax returns with EOHHS to verify MassHealth coverage, DHCFP to determine if a taxpayer who claimed a religious exemption used the Health Safety Net Trust Fund, and with the Connector to process appeals and to conduct outreach to uninsured taxpayers.

Proposed Amendment Language: Section 12 of chapter 62E of the General Laws, as amended by sections 14 and 15 of chapter 324 of the acts of 2006 and section 1 of chapter 450 of the acts of 2006, is hereby further amended by inserting after the second paragraph the following paragraph:-

Notwithstanding the provisions of any law to the contrary, the Commissioner may disclose any information referred to in this chapter to the Commonwealth Health Insurance Connector Authority, the Division of Health Care Finance and Policy and the Executive Office of Health and Human Services under an interagency agreement for purposes of the administration or enforcement of the provisions of Chapter 58 of the Acts of 2006 and amendments thereto.

Section 21(b) of chapter 62C of the General Laws, as amended by section 12 of chapter 324 of the acts of 2006, is hereby further amended by inserting the following new subsection:-

(23) the disclosure of any information contained in a return filed pursuant to this chapter to the Commonwealth Health Insurance Connector Authority, the Division of Health Care Finance and Policy and the Executive Office of Health and Human Services under an interagency agreement for the enforcement or administration of the provisions of Chapter 58 of the Acts of 2006 and amendments thereto.

3) **Allowing Use of Social Security Numbers by MassHealth & Authorization for DOR to Release Information to EOHHS:** As

described above, DOR is responsible for documenting compliance with the individual mandate. The current plan is for insurance carriers, certain employers and MassHealth to issue a 1099-HC to each subscriber and to DOR to verify coverage. Current law prohibits the use of Social Security numbers in connection with the 1099-HC requirement. The following two amendments would make an exception for MassHealth because in most cases the MassHealth policy number is the Social Security number. The second amendment allows DOR to release 1099-HC data to the Executive Office of Health and Human Services.

Proposed Amendment Language: Section 7B of chapter 26, as most recently amended by chapter 324 of the Acts of 2006, is hereby further amended by striking subsection (b) and inserting in place thereof the following language: - (b) Upon request, carriers licensed under chapters 175, 176A, 176B and 176G and the office of Medicaid shall make information available to the bureau, but such information shall be limited to the minimum amount of personal information necessary for the purposes of said chapter 111M. Such information shall not include information about previous or current diagnoses or treatments or, except in the case of the office of Medicaid, Social Security numbers. The information acquired under this section shall be confidential and shall not constitute a public record.

Subsection (c) of section 8B of chapter 62C as enacted by section 11 of chapter 324 of the Acts of 2006 is hereby amended by striking subsection (c) and inserting in place thereof the following new subsection (c): - (c) The statements and reports shall identify the carrier or employer, the covered individual and covered dependents, the insurance policy or similar numbers and the dates of coverage during the year, and shall provide other information as required by the commissioner of revenue; but shall be limited to the minimum amount of personal information necessary for the purposes of said chapter 111M. Such information shall not include information about previous or current diagnoses or treatments or, except in the case of the office of Medicaid, social security numbers. The Commissioner of Revenue, in consultation with the Commissioner of Insurance, may specify the content and format of the statements and reports. The Commissioner of Revenue may disclose the information in the statements and reports to the Division of Insurance, the Division of Health Care Finance and Policy, the Executive Office of Health and Human Services and the Commonwealth Health Insurance Connector. The information in the statements and reports shall be confidential and shall not constitute a public record.

4) **Authorization for DOR to Share Information with HSNO**: The following two amendments allow the Department of Revenue to share wage reporting information with the Health Safety Net Office in order to

determine financial eligibility and to intercept tax refunds to recover payments owed to the Health Safety Net Trust Fund.

Proposed Amendment Language: Section 60(c) of chapter 118E as enacted by section 30 of chapter 58 of the Acts of 2006 and recently amended by section 21 of chapter 324 of the Acts of 2006 is hereby further amended by replacing section 60(c) with the following:-
(c) The health safety net office shall enter into interagency agreements with the Department of Revenue to verify income data for patients whose health care services are reimbursed by the Health Safety Net Trust Fund and to recover payments made by the fund for services provided to individuals who are ineligible to receive reimbursable health services or on whose behalf the fund has paid for emergency bad debt. Such written agreements shall include provisions permitting the Department of Revenue to examine the data available under the wage reporting system established under section 3 of chapter 62E. The Department of Revenue is hereby authorized to furnish the health safety net office with information on the cases of persons so identified, including, but not limited to, name, Social Security number and other data to ensure positive identification, name and identification number of employer, and the amount of wages received. The Health Safety Net Office shall promulgate regulations requiring acute hospitals to submit data that will enable the Department of Revenue to pursue recoveries from individuals who are ineligible for reimbursable health services and on whose behalf the fund has made payments to acute hospitals for such services or for emergency bad debt. The Health Safety Net Office shall be deemed a claimant agency under section 1 of chapter 62D and any amounts owed to the Health Safety Net Trust Fund shall be considered a debt under section 1 of chapter 62D. The Health Safety Net Office shall request the department of revenue, pursuant to the provisions of chapter 62D and under an interagency agreement, to withhold amounts from state tax refunds of any person who had services paid by the Health Safety Net Trust Fund but is determined ineligible for reimbursable health services or on whose behalf the fund has made payments for emergency bad debt, and the Department of Revenue is hereby authorized to withhold said offset refund amounts. Any amounts recovered shall be deposited in the Health Safety Net Trust Fund, established by section 57 of chapter 118E.

Section 13 of chapter 62D of the General Laws, as appearing in the 2004 Official Edition, is hereby amended by adding the following after the words “section 18 of chapter 118G;”: - (ix) any overdue debt certified by the comptroller as due and owing to a city or town or to an agency of a city or town, to a housing authority or to a state authority as defined in section 1 of chapter 29; and (x) debts owed the Health Safety Net Office.

5) **Clarification of "Individual Mandate" Section:** The individual mandate section currently applies to "every person who files an individual return." The following amendment would clarify that the individual mandate applies to every person who files or is "required to file" a tax return.

Proposed Amendment Language: Subsection (b) of section 2 of chapter 111M, as most recently added by section 12 of chapter 58 of the Acts of 2006, is hereby amended by inserting after the word "files", in the first sentence, the following words: - or is required to file.

Health Care Quality and Cost Council

1) ***Authorization for Collection of Data from Third Party Administrators:*** The Massachusetts Health Care Quality and Cost Council, established under MGL c.6A, s.16J, is charged with collecting and publishing health care information for consumers on the Internet. The Council is authorized to collect data from insurers and health care providers. The Council needs the authority to collect data from Third Party Administrators as well, because these entities administer the data for approximately half of all private payer health care claims.

Proposed Amendment Language: SECTION XXI: Section 16J of chapter 6A, as added by chapter 58 of the acts of 2006 is hereby amended by inserting after the definition of "Physician Group Practice" the following definition: - "Third Party Administrator", an entity that administers payments for health care services on behalf of a client plan in exchange for an administrative fee.

SECTION XXII: Section 16L of chapter 6A, as added by chapter 58 of the acts of 2006 is hereby amended by striking out paragraph (d) and inserting in place thereof the following paragraph: - (d) Insurers, third party administrators, and health care providers shall submit data to the council or to the independent organization on behalf of the council, as required by regulations promulgated under subsection (e). If any insurer, third party administrator, or health care provider fails to submit required data to the council on a timely basis, the council shall provide written notice to the insurer, administrator or provider. If the insurer, third party administrator, or health care provider fails, without just cause, to provide the required information within 2 weeks following receipt of said written notice, the insurer, administrator, or provider may be required to pay a penalty of $1,000 for each week of delay; provided, however, that the maximum penalty under this section shall be $50,000.

2) ***Deadlines for Creation of Website and Posting of Cost Information:*** St. 2006, c.58, s.136 required the Massachusetts Health Care Quality and Cost Council to establish a website by July 1, 2006 and to include

comparative cost information by January 1, 2007. The following language establishes more realistic deadlines.

In addition, the current language of the statute directs the Council to post data that has been aggregated for all insurers, but not data on an insurer by insurer basis. The Council believes that this restriction may limit the usefulness, accuracy and accessibility of cost data which it makes available to Massachusetts consumers. Because consumers enrolled in high deductible plans pay providers at the rates negotiated by their health plan, the Council would have to report average price data by payer, as well as by procedure and by provider, in order to enable consumers to see the expected price at each provider site.

Proposed Amendment Language: SECTION XXIV. Chapter 58 of the Acts of 2006 is hereby amended by striking out section 136 and inserting in place thereof the following section: - Section 136. The website to be established pursuant to section 16L of chapter 6A of the General Laws shall be operational not later than September 1, 2007, and shall include, at a minimum, links to other Internet sites that display comparative cost and quality information. Not later than March 1, 2008, the Internet site shall, at a minimum, include comparative cost information by facility and, as applicable, by clinician or physician group practice for obstetrical services, physician office visits, high-volume elective surgical procedures, high-volume diagnostic tests and high-volume therapeutic procedures. Cost information shall include, at a minimum, the average payment for each service or category or service received by each facility, clinician or physician practice on behalf of insured patients.

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